

# SB 07 and HB 4572 implications for self-insured community colleges

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**Background.** First, let me say that I support the proposition that taxpayers should not be paying 100% or 95% or 90% or even 85% of the cost of providing healthcare to public sector employees. I also strongly believe that, in addition to the question of who pays what percentage, public employers must rise to the challenge of containing overall healthcare expenditures.

I am in my tenth year as president of Southwestern Michigan College (SMC), and we have deliberately and systematically addressed both of these issues. SMC has increased the portion of healthcare costs that employees pay. Currently, as a group, our employees pay 23-24% of the total cost of their healthcare each year.

A critical component to SMC's comprehensive solution to healthcare cost containment is that the College is self-funded rather than fully insured. We have crafted a plan with relatively large co-pays (\$40 name brand RX) and relatively high out of pocket maximums. This has allowed us to keep the monthly contribution lower for employees, and to incentivize employee participation in our "standard" rather than "premier" plan.

SMC's strategy of structuring insurance benefits so that employees pay more at the point of usage is the RIGHT strategy according to the expert healthcare consultants that we have engaged in this process. This structure has less of the dollars being paid to healthcare through the third party, and more of the dollars directly from the employees – a critical factor in controlling healthcare costs.

**The Fundamental Problem with SB 07.** Even though SMC employees pay in total well over 20% of the total cost of their healthcare, SMC WOULD NOT be in compliance with the current version of SB 07. As currently written, SB 07 specifically precludes counting the dollars spent by employees at the point of usage as part of their contribution. It would therefore penalize those colleges such as SMC that have done the right thing, and would dis-incentivize passing costs of using healthcare services directly to the employees.

**Many Solutions Exist to fix this fundamental problem.** There are at least three different ways that SB 07 could be amended so as not to penalize colleges that have already managed to shift substantial health care costs to employees.

- Exempt community colleges that are self-funded from the legislation. (The legislation is fundamentally structured to address fully insured plans where employee copays and out of pocket expenses are minimal, rather than self-funded plans that may be structured quite differently.) This would be very simple to implement. OR
- Allow self-funded community colleges to set employee contributions using TOTAL healthcare costs from the previous year, requiring that in total employees pay 20% of the cost of their healthcare. Employee share would specifically include out-of-pocket costs of copays and deductables. This language would have to be very carefully drafted. OR
- Allow Michigan Community Colleges to "opt out" of this requirement by a 2/3 vote of the Board. It is the position of SMC that the Michigan Constitution clearly vests supervision and control of community colleges with the locally elected boards. Article VIII, Section 7 of the Constitution states "The legislature shall provide by law for the establishment and financial support of public community and junior colleges which shall be supervised and controlled by locally elected boards." Pay and benefits are issues of supervision and control.

Although any one of the above solutions would allow the legislature to address this critical issue without throwing out the well-managed baby with the poorly managed bath water, the third "opt out" option is best

because it solves the fundamental problem and doesn't raise the possibility of a constitutional legal challenge to SB 07 by one or more community colleges.

**There are at least two additional problems with SB 07 that also must be addressed.** First, as written, it appears that SB 07 would mandate a change in health insurance plans effective January 1, 2012 unless a collective bargaining agreement is currently in place. As written, this would require non-unionized institutions like SMC to change mid-plan year. This would be highly disruptive at best, and completely unworkable at worst.

Second, the provision in SB 07 that "... a public employer that offers a medical benefit plan that includes a health savings account as permitted in section 223 of the internal revenue code of 1986, 26 USC 223, shall increase the amount it pays toward the annual total cost of an employee's or public official's medical benefit plan by an amount equivalent to the amount the employee or public official contributes to the health savings account, and that increase shall be excluded from the maximum public employer expenditure otherwise permitted under this section." appears to burden the employer with matching any amount of employee contribution toward the HSA. This appears entirely inconsistent with the intent of the overall bill, and would introduce a new, uncontrolled, cost for public employers.

**With regard to HB 4572, there are three issues.** First, because SMC has aggressively controlled costs, we are very near the \$5,000 individual and \$10,000 two-person employer expenditures set forth in the bill. However, full-family coverage under ANY plan is 3 times the individual rate, so the hard cap of \$13,000 appears arbitrarily low. If this hard cap for families were at \$15,000 then these limits of 5K-10K-15K would closely align with the employer costs of our aggressively managed plan where employees do pay 23-24% of total healthcare costs when all out of pocket costs are considered.

Second, and more problematic, is the mechanism for annually adjusting these hard caps. HB 4572 fundamentally ties increases in these caps to the Consumer Price Index (CPI). As you are aware, healthcare costs nationally have been increasing at double digits annually even though the CPI changes have ranged from -0.4 to +3.8 percent annually for the last decade. Insurance experts predict that for 2011 healthcare costs will increase between 9 and 11 percent. Unless the goal is to effectively annually increase the percentage of healthcare costs paid by employees forever, this adjustment mechanism would have to be indexed by something other than the CPI.

Finally, Sec. 9 of HB 4572 states "The requirements of section 5 apply to all public employees to the greatest extent consistent with constitutionally allocated powers." This explicitly raises the constitutional issue regarding community college supervision and control. Again, it is the position of Southwestern Michigan College that Michigan's Constitution is clear in granting both "supervision" and "control" to locally elected governing boards, and that issues of pay and benefits therefore fall under the jurisdiction of the locally elected board.

In summary, it is obvious that public employers have the responsibility to control overall health care expenditures, and to also ensure that their employees are paying their "fair" share. Southwestern Michigan College has done both of these things. It is my hope that any legislation that forces public employers to follow a similar path will not penalize organizations that have already accomplished this goal, will recognize employee's payment for services as part of their contributions, will recognize the complexities associated with this issue, and will acknowledge the authority of locally elected community college boards as set forth in the Michigan Constitution.



## Southwestern Michigan College, G-733

	In-Network	Out-Of-Network	In-Network	Out-Of-Network
Deductible per Calendar Year	\$300/person \$600/family	\$600/person \$1,200/family	\$1,000/person \$2,000/family	\$2,000/person \$4,000/family
General Benefit Percentage	90% after deductible	60% after deductible	80% after deductible	50% after deductible
Out-Of-Pocket Maximum per Calendar Year (Includes Deductible and Benefit Percentage)	\$2,500/person* \$5,000/family*	\$5,000/person* \$10,000/family*	\$4,000/person* \$8,000/family*	\$6,000/person* \$12,000/family*
*Does not include in-network co-payments, prescription drug co-payments, or expenses that constitute a penalty for non-compliance, exceed the usual and customary charge, exceed the limits of the Plan, are subject to the Pre-Existing Conditions limitation, or are otherwise excluded.				
Prescription Drugs		\$-0-eligible over-the-counter drug, \$10/generic drug, \$40/brand-name drug	\$-0-eligible over-the-counter drug, \$20/generic drug, \$80/brand-name drug	\$-0-eligible over-the-counter drug, \$10/generic drug, \$40/brand-name drug
Retail Prescription Drug Co-payments (34-Day Supply or 100 Unit Doses)				
Mail-Order Prescription Drug Co-payments (90-Day Supply)				
<b>NOTE:</b> 1. The pharmacy will dispense generic drugs unless the prescribing physician requests "Dispense as Written" (DAW) or a generic equivalent is not available. If the covered person refuses an available generic equivalent and the prescribing physician has not requested DAW, the covered person must pay the applicable co-payment <b>plus</b> the difference in price between the brand-name drug and its generic equivalent. 2. Claritin available over-the-counter and Prilosec OTC will be covered under the Plan and shall be subject to the co-payments shown above. A physician's prescription for these products is required.				
Outpatient Physician Services	\$15 co-payment then 100% (deductible waived)	60% after deductible	\$30 co-payment then 100% (deductible waived)	50% after deductible
Office Visits				
Immediate Care Visits				
Routine Preventive Care	\$15 co-payment, then 100% (deductible waived)	Not covered	\$30 co-payment, then 100% (deductible waived)	Not covered
Routine Office Visits	100%; deductible waived	Not covered	100%; deductible waived	Not covered
All Other Routine Services	\$500*		\$500*	
Maximum Paid per Covered Person per Calendar Year for All Routine Preventive Care				
*Routine mammograms and immunizations are not subject to the calendar year dollar maximum shown above. Colonoscopies performed for routine screening purposes will be paid the same as any other surgical procedure, not as a routine preventive care expense.				
Outpatient X-ray & Lab	100%; deductible waived	60% after deductible	100%; deductible waived	50% after deductible
Authorization Requirement	Required for all inpatient hospital admissions and certain outpatient services listed at the end of this summary		Required for all inpatient hospital admissions and certain outpatient services listed at the end of this summary	
\$250 Penalty for Non-Compliance				
Inpatient Hospital Services	90% after deductible	60% after deductible	80% after deductible	50% after deductible
Room and Board				
Surgical Services				
Ancillary Services				

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Service Description	Premises Plan	In-Network	Out-Of-Network	In-Network	Out-Of-Network
<u><b>Emergency Care</b></u>					
Emergency Room Physician Visit	90% (deductible waived) if treated at an in-network facility	60% after deductible if treated at an out-of-network facility	80% (deductible waived) if treated at an in-network facility	50% after deductible if treated at an out-of-network facility	50% after deductible if treated at an out-of-network facility
Emergency Room Facility Fee	\$100 co-payment per visit, then 90% (deductible waived)	\$100 co-payment per visit, then 60% after deductible	\$150 co-payment per visit, then 80% (deductible waived)	\$150 co-payment per visit, then 50% after deductible	\$150 co-payment per visit, then 50% after deductible
Ambulance	90% after deductible if delivered to an in-network facility	60% after deductible if delivered to an out-of-network facility	80% after deductible if delivered to an in-network facility	50% after deductible if delivered to an out-of-network facility	50% after deductible if delivered to an out-of-network facility
<u><b>Outpatient Services</b></u>					
Surgery and Surgery-Related Services	90% after deductible	60% after deductible	80% after deductible	80% after deductible	50% after deductible
Chemotherapy					
Radiation Therapy					
Hemodialysis					
Convalescent Care	90% after deductible	60% after deductible	80% after deductible	80% after deductible	50% after deductible
Home Health Care	90% after deductible	60% after deductible	80% after deductible	80% after deductible	50% after deductible
Hospice	90% after deductible	60% after deductible	80% after deductible	80% after deductible	50% after deductible
Durable Medical Equipment	90% after deductible	60% after deductible	80% after deductible	80% after deductible	50% after deductible
Prosthetics and Orthotics	90% after deductible	60% after deductible	80% after deductible	80% after deductible	50% after deductible
<u><b>Rehabilitative Therapy</b></u>					
Physical Therapy	90% after deductible	60% after deductible	80% after deductible	80% after deductible	50% after deductible
Speech Therapy					
Occupational Therapy					
<u><b>Chiropractic Care</b></u>					
Maximum Charge Allowed per Covered Person per Calendar Year for X-Rays	\$15 co-payment per visit, then 100% (deductible waived)	\$15 co-payment per visit, then 100% (deductible waived)	\$30 co-payment per visit, then 100% (deductible waived)	\$30 co-payment per visit, then 100% (deductible waived)	\$30 co-payment per visit, then 100% (deductible waived)
Maximum Paid per Covered Person per Calendar Year for All Chiropractic Care	\$200 for in-network and out-of-network services combined	\$1,000 for in-network and out-of-network services combined	\$200 for in-network and out-of-network services combined	\$1,000 for in-network and out-of-network services combined	\$1,000 for in-network and out-of-network services combined
<u><b>Temporomandibular Joint Dysfunction (TMJ) Treatment</b></u>					
Lifetime Maximum Paid per Covered Person for All Non-Surgical TMJ Treatment	Paid the same as any other illness	\$500* for in-network and out-of-network services combined	Paid the same as any other illness	\$500* for in-network and out-of-network services combined	Paid the same as any other illness

\*The Plan will also allow for charges for surgery, if all other means of generally accepted treatment have been exhausted.

		In-Network	Out-Of-Network	In-Network	Out-Of-Network
Obesity Treatment		Paid the same as any other illness	\$20,000 for in-network and out-of-network services combined		Paid the same as any other illness
	Lifetime Maximum Paid per Covered Person for Medically Necessary Treatment of Obesity and Morbid Obesity, including Surgery and Any Related Preoperative and Post-Operative Care				\$20,000 for in-network and out-of-network services combined

  

Behavioral Care (includes Mental Health Care and Addictions Treatment)		Paid the same as any other illness			
Inpatient/Partial Hospitalization Services					
Outpatient/Intensive Outpatient Services					

  

Lifetime Maximum Paid per Covered Person		\$5,000,000 for in-network and out-of-network services combined			\$5,000,000 for in-network and out-of-network services combined

**Motor Vehicle Exclusion (Michigan Residents Only)**  
**BENEFITS ARE NOT PAYABLE UNDER THIS PLAN FOR INJURIES RECEIVED IN AN ACCIDENT INVOLVING A MOTOR VEHICLE AS DEFINED IN THE PLAN.** It is your responsibility to obtain proper motor vehicle insurance that will give you and your family medical benefits. If you fail to maintain your motor vehicle insurance, you will not have any medical expense coverage for auto-related injuries. This exclusion shall not apply to a covered person who is a Michigan resident involved in an accident outside the state of Michigan for which Michigan no-fault coverage is not legally available. However, this exclusion shall apply if a covered person is injured while in his or her own uninsured motor vehicle for which a Michigan no-fault policy is legally required and would have provided coverage, had such a policy been in effect.

**Coordination with Other Coverage for Injuries Arising out of Automobile Accidents (Non-Michigan Residents Only)**  
The following special coordination rule applies regarding automobile insurance. If a covered person has automobile insurance (including, but not limited to no-fault) that provides health benefits, the automobile insurance shall be the primary plan and this Plan shall be the secondary plan for purposes of paying benefits.

**Dependent Spouse Exclusion**  
A participant's spouse who is eligible for coverage under his or her own employer's group health plan as a full-time employee should enroll for that coverage. Such a spouse will not be eligible to participate in or be covered under this Plan. A participant's spouse who is eligible for coverage under his or her own employer's group health plan as a part-time employee will not be subject to this provision and will not be penalized for declining to enroll for such coverage.

**Services Requiring Authorization:**

1. Inpatient hospital confinements
2. Home and outpatient rehabilitative therapy
3. Rental and purchase of durable medical equipment
4. Home health care
5. Purchase of custom-made orthotic or prosthetic appliances
6. Oncology treatment

**Personal Care Physician (PCP).** A PCP must be selected when enrolling in the above plan. PCPs are highlighted in the Physicians Care directory. When you seek medical services, contact your PCP, who will treat you or refer you to a specialist.

Claims resulting from Pre-Existing Conditions are excluded from coverage for up to 12 months from the covered person's enrollment date. The Pre-Existing period will be reduced by the covered person's days of prior creditable coverage (HPPA). The term Pre-existing Condition means a physical or mental condition of a covered person for which medical advice, diagnosis, care, or treatment was recommended or received within the six months before the covered person's enrollment date.

If a Covered Person receives eligible treatment at an In-Network facility, any anesthesiology, pathology, or radiology charges will be paid at the In-Network benefit percentage, even if Out-of-Network providers performed those services.

Benefit Type	Benefit Description	Limits
Deductible		\$50/person \$150/family
<u>Benefit Percentage</u>		100%; deductible waived
Type I - Preventive Dental Services	Type II - Minor Restorative Dental Services	80% after deductible
Type III - Major Restorative Dental Services	Type IV - Orthodontic Services (for Dependent children under age 19 only)	50% after deductible
Maximum Benefit Paid per Covered Person per Calendar Year for Types I, II & III Dental Services	Lifetime Maximum Benefit Paid per Dependent Child for Type IV Orthodontic Services	\$1,000
<b>Type I - Preventive Dental Services</b>	<b>Type II - Minor Restorative Dental Services</b>	<b>Type III - Major Restorative Dental Services</b>
Oral Examination and Dental Prophylaxis (cleaning teeth)	Stainless Steel Crowns	Gold Inlays and Onlays
Complete Series or Panorex X-ray	Porcelain Restorations	Porcelain Restorations
Bite-Wing X-rays	Replacement of Teeth to Bridges and Dentures	Replacement of Teeth to Bridges and Dentures
Fluoride Treatment	Full and Partial Dentures	Full and Partial Dentures
Sealants	Fixed Bridges and Dental Implants	Fixed Bridges and Dental Implants
Emergency Treatment	<b>Type IV - Orthodontic Services (Dependent Children Under 19 Only)</b>	Orthodontic Diagnostic Procedures, Surgical Therapy, and Appliance Therapy
		No special limitations.

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Southwestern Michigan College

2010 Plan Year

Deductible (Individual/Family)			
In-Network	\$0/\$0	\$300/\$600	\$1,000/\$2,000
Out-Of-Network	\$250/\$500	\$600/\$1,200	\$2,000/\$4,000
Co-Insurance Maximum (Individual/Family)			
In-Network	\$0/\$0	\$2,500/\$5,000	\$4,000/\$6,000
Out-Of-Network	\$2,000/\$4,000	\$5,000/\$10,000	\$8,000/\$12,000
General Benefit Percentage (In/Out of Network)	100%/80%	100%/80%	80%/20%
Office Visit/Urgent Care/ER Copay	\$5/\$10/\$25	\$15/\$15/\$100 then 90%	\$30/\$30/\$150 then 80%
Prescription Drugs			
Generic/Preferred Brand/Non Preferred Brand	\$5/\$10	\$10/\$40	\$15/\$50
Mail Order	1x retail copay	2x retail copay	2x retail copay
Dental	80/80/80/80/\$1,000/\$1,300	100/80/50/50/\$1,000/\$750	100/80/50/50/\$1,000/\$750
Vision	VSP 3	none	none
Single	44	\$8,170.91	\$6,107.52
Double	35	\$18,226.77	\$12,215.04
Family	49	\$20,730.23	\$17,101.08
Total Annual Cost	128	\$2,013,238.26	\$1,534,210.20